SHOPPING FOR HEALTH CARE

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Will consumers some day be able to shop for health care the way they shop for groceries? As farfetched as that idea may seem, some believe it will become a reality. But in order for patients to become savvy shoppers in the medical marketplace, they must be able to discover what things cost and to compare prices as well as value. Today, that is not easy to do.

A recent Harris Poll found that consumers can guess the price of a new Honda Accord within $300. But when asked to estimate the cost of a four-day stay in the hospital, those same consumers were off by $8,100! Further, 63 percent of those who had received medical care the last two years did not know the cost of the treatment until the bill arrived. Ten percent said they never learned the cost.[1]

This is not an academic issue. If you are like most other Americans, your employer has raised your health insurance deductible and copayment within the last few years. And, you may have a special account from which to pay bills directly. Increasingly, employees are being asked to make their own choices and manage their own health care dollars.

[1] Kathy Gurchiek,"Consumers savvier about cost of a new care than a hospital stay," *Human Resource News*, August 2, 2005.

The medical marketplace is not prepared for these changes. Not only do patients typically not know the cost of the medical services they receive, the institutions of health care delivery often make price and quality information difficult, if not impossible, to obtain.

Why is information consumers have ready access to in other markets not generally available in health care? What institutional and technological changes are needed in order to make such information routinely available prior to health purchases? What is the appropriate role for public policy?

Source of the Problem

The principal reason why prices are not publicly quoted and commonly known in health care is that prices do not serve the function in health care that they do in other markets. Specifically, doctors and hospitals do not compete on the basis of price and prices do not ration scarce resources the way they do in other markets.

Although ours is a very different system from the health care system of Canada,[2] the way in which we pay providers in both countries is surprisingly similar. In general, fees are set by third-party institutions and those institutions pay all, or almost all, of those fees.

On the average, every time Americans spend a dollar on physicians' services, only 11 cents is paid out-of-pocket; the remainder is paid by a third party (an employer,

[2] John C. Goodman, Gerald L. Musgrave, & Devon M. Herrick. *Lives at Risk: Single-Payer National Health Insurance Around the World.* (Lanham, Maryland: Rowman and Littlefield Publishers, 2004.)

insurance company or government).[3] From a purely economic perspective, then, our incentive is to consume these services until their value to us is only 11 cents on the dollar. Moreover, millions of Americans do not even pay the 11 cents. Medicaid enrollees, Medicare enrollees who have medigap insurance, and people who get free care from community health centers and hospital emergency rooms pay nothing at the point of service. Most members of HMOs and PPOs make only a modest copayment for primary care services. Clearly we are not rationing health care on the basis of price.

But if not price rationing, how do we ration physicians' services? We ration the same way other developed countries ration care. We force people to pay for care with their time. The services of physicians are a scarce resource and a valuable resource. So at a price of zero (or at a very low out-of-pocket price) the demand for these services far exceeds supply. Unable to bring supply and demand into balance with money prices, our system does that next best thing. We ration by waiting.

Some may object that the real demand for physicians' services is not determined by time or money but by the amount of sickness in society. Yet this view is surely wrong.[4] Consider that 12 billion times a year Americans purchase over-the-counter (OTC) drugs and suppose that on their way to these acts of self-medication all of the purchasers stopped to get professional advice. To meet that demand, we would need 25 times the number of primary care physicians we currently have![5]

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[3] K. Levit, C. Smith, C. Cowan, H. Lazenby, A. Sensenig, & A. Catlin. 2003. "Trends in U.S. Health Care Spending, 2001" *Health Affairs*, *22*(1), pp. 154-164.

[5] Simon Rottenberg. "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, 1990, *13*(2), 27-28.

Now suppose that instead of physically going to a doctor's office, purchasers of OTC drugs could get professional advice by means of telephone or email. The same problem would arise. The demand for advice would far exceed the ability of physicians to supply it.

In general, patients cannot have the best of both worlds. If they communicate with doctors the way they communicate with lawyers, they will have to be charged money prices for the use of the doctor's time (the way they pay legal fees). Health care cannot be both easily accessible and free. It must be one or the other. Waiting is not an accidental by product of modern health care delivery. It is an essential ingredient.

What difference does this make? A great deal of difference. In general, if doctors do not compete with each other on the basis of price, they do not compete at all.

One consequence of rationing by waiting is that the time of the primary care physician is usually fully booked, unless she is starting a new practice or working in a rural area. This means that almost all the physician's hours are spent on billable activities. Further, there is very little incentive to compete for patients the way other professionals compete for clients. The reason: neither the loss of existing patients nor a gain of new patients would affect the doctor's income very much. Loss of existing patients for example, would tend to reduce the average waiting time for the remaining patients. But with shorter waiting times, those patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency we use to pay for care, the physician doesn't benefit (very much) from patient

pleasing improvements and is not harmed (very much) by an increase in patient irritations.

What about the hospital sector? As is the case for physician services, fees for hospital services are set and paid by third-party payers. And, as is the case for physician services, the scarce resource again is the doctor's time. Here, however, it is not patients who are waiting on doctors; it is hospital beds (and other facilities) that wait on doctors.

In many ways, the two sectors are mirror images of each other. In neither sector do prices clear markets. And in neither sector is competition among providers based on price.

Can Health Markets be Different?

There is nothing normal or natural about rationing by waiting. The exterior offices of lawyers, accountants, architects and other professionals are called "reception areas," not "waiting rooms," and very little waiting actually goes on. The reason: waiting is a wasteful way to allocate resources. In markets for other goods and services, the consumer's cost is typically the producer/seller's income. But when people pay for goods with their time, their waiting cost is not someone else's income. It is a net social loss.

Rationing by waiting is not only socially wasteful, it is a poor way of delivering health care. Under such a system, there is no way to insure that those who need care the most get it first, or even get care at all.[6] Human resource experts estimate that one-

[6] Goodman, et al. *Lives at Risk*.

quarter of physicians visits are for conditions that patients could easily treat themselves.[7] Balanced against these "unnecessary" visits are all of the potential visitors who choose not to seek care. Undoubtedly, many of those are "necessary" but unrealized visits; and, hence, the patients go without professional treatment.

To find radically different physician behavior, one must look at markets where third-party payers are not involved at all, such as the markets for cosmetic and lasik surgery. Unlike other forms of surgery, the typical cosmetic surgery patient can (a) find a package price in advance covering all services and facilities, (b) compare prices prior to the surgery and (c) pay a price that is lower in real terms than the price charged a decade ago for comparable procedures — despite the considerable technological innovations in the interim.[8]

Ironically, many physicians who perform cosmetic surgery also perform other types of surgery. The difference in behavior is apparently related to how they are paid. A cosmetic surgery transaction has all the characteristics of a normal market transaction in which the seller has a financial interest in how all aspects of the transition affect the buyer. In more typical doctor-patient interactions, doctors are not paid to be concerned about all aspects of care and therefore typically ignore the effects on the patient of the cost of time, the cost of drugs, and other ancillary costs. Note, this holds for HMO doctors as well as fee-for-service doctors and what is true for U.S. doctors in general is

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[7] D.R. Powell, "Implementing a Medical Self-Care Program," *Employee Benefits Journal*, International Foundation of Employee Benefit Programs. September 2003.

[8] Devon Herrick. "Why Are Health Costs Rising?" *National Center for Policy Analysis*, Brief Analysis No. 437, 2003.

also true of doctors who practice in the government-run health systems of other developed countries.

Whenever there is waste and inefficiency in a market, there is an opportunity for entrepreneurs to make profits by eliminating that waste and inefficiency. The health care market is no exception. What makes entrepreneurship difficult in health care is that in order to eliminate waste and inefficiency, the entrepreneurs must step outside of the normal payment mechanisms. This means that patients who take advantage of these services often must pay out-of-pocket for what theoretically should be covered by their insurer.

The entrepreneurial activities we have identified tend to have two characteristics: (a) they allow patients to economize on time and (b) they step outside the normal reimbursement channels, usually asking for payment at the time of service. Here are some examples:

- *Minute clinics.* These are walk-in clinics located in selected Target and Club Food stores and some CVS Pharmacies, and Wal-Mart has signaled its interest in providing a similar service through its stores nationwide. They are staffed by nurse practitioners. No appointments necessary and most office visits take only 15 minutes. Treatments range from $25 to $105. In contrast to standard physician practice, medical records are stored electronically and prescriptions are also ordered that way.

- *TelaDoc.* This service offers medical consultations by telephone. A doctor usually returns patient's calls within 30 to 40 minutes. If the call is returned later than 3 hours the consultation is free. Access is available around the

clock. Registration for the service costs $18. Phone consultations are $35 each, with a monthly membership fee ranging from $4.25 to $7.

- *Doctokr.* This is the Virginia medical practice of Dr. Alan Dappen. Although he offers in-office appointments, he encourages most patients to have either an e-mail consultation or a phone consultation. Dappen charges based on the amount of time required. A simple consultation generally costs less than $20.
- *CashDoctor.com.* This is a loosely-structured network for doctors across the country that are "cash friendly." Practices styles and fee schedules are available online.

Is Needed Technology Available?

It is possible to have a health care system in which third-party payers neither set the fees nor pay the fees of providers. For example if health insurance worked like casualty insurance (the type of insurance people purchase for their homes and automobiles), insurance reimbursements would cover the expected cost of care for most providers; but patients would be free to negotiate with individual providers and pay more (for better service) if they found extra value warranted the extra charge.

Even in this imaginary market, however, there has to be a way for patients to gain access to price and quality information. So how exactly would that work? Some assume that we need a new government program to kick-start needed technological changes. Yet while pundits talk and politicians threaten to legislate, the private sector already has developed many of the tools to solve these problems.

- In the market for drugs, the web site Rxaminer.com allows patients to discover therapeutic and generic substitutes for brand name drugs as well as over-the-counter alternatives; the site DestinationRx.com allows patients to compare prices nationwide.
- A model developed by Health Market allows its insureds to compare the price they will pay for 20,000 procedures performed by virtually every doctor in the country.
- A product developed by Simbro allows patients to compare quality and price data for most hospitals in the country.
- A product developed by eMedical*files* creates needed transparency for doctors – it allows medical records to travel electronically as patients go from doctor to doctor and hospital to hospital.

What Public Policy Changes are Needed?

If we do not need government to fund or regulate new technologies, what changes are needed? New government policies can help in two ways. First, in markets where government is the primary third-party payer (e.g., Medicare or Medicaid), policymakers can use existing technology to let its own insureds have access to price and quality information. (Some modest steps in the right direction are already underway.)

Second, we need to change the tax law to make it easier for people to self-insure for medical expenses instead of over-relying on third-party insurance. In order to have a workable, well-functioning medical marketplace, we need to fundamentally change the

way we pay for health care, including the way we pay doctors. A step in the right direction is the creation of Health Savings Accounts (HSAs). Instead of an employer or insurer paying all the medical bills, about 3.2 million people are managing some of their own health care dollars through these accounts and another 3 million have Health Reimbursement Arrangements.[9]

Despite their many advantages, HSAs can be made even better. Under the current system, HSA plans with deductibles and copayments graph onto the current payment system and reinforce it rather than challenge it. Under the current HSA rules, if a patient pays for care with dollars, those dollars count toward a deductible and move the patient closer to the point when a third-party will pay all remaining financial costs. But if a patient pays for care with time, this does not count toward the deductible. Further under most HSA plans, time-saving innovations are typically not covered expenses. In these ways, most HSA plans are tacked on to the existing payment system, rather than an alternative to it.

The current HSA law's primary problem is that decisions the market should make have been made by the tax-writing committees of the U.S. Congress instead. What is the appropriate deductible for which service? How much should be deposited in the HSAs of different employees? How can we use these accounts to meet the needs of the chronically ill? In finding answers, markets are smarter than any one of us because they benefit from the best thinking of everyone. Further, as medical science and technology advance, the best answer today may not be the best answer tomorrow.

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[9] Source: HealthMarket Survey, U.S. Census Bureau and Americas Health Insurance Plans (AHIP), 2006.